

Facility Name & ID Number St. Ann's Healthcare Center# 0023390 Report Period Beginning: 01-01-2004 Ending: 12-31-2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,712</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>87</u>	Intermediate (ICF)	<u>87</u>	<u>31,842</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,554</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,004</u>	<u>466</u>	<u>3,109</u>	<u>5,579</u>	8
9	SNF/PED					9
10	ICF	<u>13,011</u>	<u>8,063</u>		<u>21,074</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,015</u>	<u>8,529</u>	<u>3,109</u>	<u>26,653</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.20%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 03-01-1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 32 and days of care provided _____Medicare Intermediary Mutual Of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 2004 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

St. Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2004

Ending:

12-31-2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	196,666	16,008	4,883	217,557		217,557		217,557		1
2	Food Purchase		130,126		130,126	(3,896)	126,230	(5,324)	120,906		2
3	Housekeeping	75,111	15,462		90,573		90,573		90,573		3
4	Laundry	56,157	16,211		72,368		72,368		72,368		4
5	Heat and Other Utilities			103,945	103,945		103,945		103,945		5
6	Maintenance	48,505	16,187	53,025	117,717		117,717	15	117,732		6
7	Other (specify):*										7
8	TOTAL General Services	376,439	193,994	161,853	732,286	(3,896)	728,390	(5,309)	723,081		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,007,083	168,774	7,950	1,183,807		1,183,807	(1,249)	1,182,558		10
10a	Therapy	49,901		350,219	400,120		400,120		400,120		10a
11	Activities	36,329	10,692	3,603	50,624		50,624		50,624		11
12	Social Services	35,467	1,772	3,560	40,799		40,799		40,799		12
13	Nurse Aide Training										13
14	Program Transportation		4,023		4,023		4,023	(4,023)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,128,780	185,261	365,332	1,679,373		1,679,373	(5,272)	1,674,101		16
	C. General Administration										
17	Administrative	54,569		72,000	126,569		126,569	(29,013)	97,556		17
18	Directors Fees										18
19	Professional Services			20,776	20,776		20,776	1,287	22,063		19
20	Dues, Fees, Subscriptions & Promotions			42,806	42,806		42,806	(31,989)	10,817		20
21	Clerical & General Office Expenses	97,981	13,838	21,512	133,331	3,896	137,227	41,949	179,176		21
22	Employee Benefits & Payroll Taxes			215,392	215,392		215,392	6,534	221,926		22
23	Inservice Training & Education			593	593		593		593		23
24	Travel and Seminar			9,660	9,660		9,660	478	10,138		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,635	78,635		78,635		78,635		26
27	Other (specify):* Sales Tax			1,660	1,660		1,660	(1,660)			27
28	TOTAL General Administration	152,550	13,838	463,034	629,422	3,896	633,318	(12,414)	620,904		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,657,769	393,093	990,219	3,041,081		3,041,081	(22,995)	3,018,086		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

St. Ann's Healthcare Center

#0023390

Report Period Beginning:

01-01-2004

Ending:

12-31-2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			69,031	69,031		69,031	1,966	70,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,503	60,503		60,503	(3,970)	56,533			32
33	Real Estate Taxes			33,028	33,028		33,028		33,028			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			162,562	162,562		162,562	(2,004)	160,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		4,023		4,023		4,023		4,023			38
39	Ancillary Service Centers		33,344		33,344		33,344	(2,034)	31,310			39
40	Barber and Beauty Shops			7,587	7,587		7,587		7,587			40
41	Coffee and Gift Shops		10,895		10,895		10,895		10,895			41
42	Provider Participation Fee			65,332	65,332		65,332		65,332			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		48,262	72,919	121,181		121,181	(2,034)	119,147			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,657,769	441,355	1,225,700	3,324,824		3,324,824	(27,033)	3,297,791			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number St. Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2004

Ending:

12-31-2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,324)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(1,249)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,970)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,660)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,023)	14		16
17	Non-Care Related Fees	(916)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(32,029)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pharmacy Billing	(2,034)	39		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,205)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	24,172		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 24,172		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (27,033)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

St. Ann's Healthcare Center

ID# 0023390

Report Period Beginning: 01-01-2004

Ending: 12-31-2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2004

Ending:

12-31-2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,324)	0	0	0	0	0	0	0	0	0	0	(5,324)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	15	0	0	0	0	0	0	0	0	15	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,324)	0	15	0	0	0	0	0	0	0	0	(5,309)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,249)	0	0	0	0	0	0	0	0	0	0	(1,249)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,023)	0	0	0	0	0	0	0	0	0	0	(4,023)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,272)	0	0	0	0	0	0	0	0	0	0	(5,272)	16
	C. General Administration													
17	Administrative	0	(4,419)	(24,594)	0	0	0	0	0	0	0	0	(29,013)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	359	928	0	0	0	0	0	0	0	0	1,287	19
20	Fees, Subscriptions & Promotions	(32,945)	0	956	0	0	0	0	0	0	0	0	(31,989)	20
21	Clerical & General Office Expenses	0	31,581	10,368	0	0	0	0	0	0	0	0	41,949	21
22	Employee Benefits & Payroll Taxes	0	4,996	1,538	0	0	0	0	0	0	0	0	6,534	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	478	0	0	0	0	0	0	0	0	478	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,660)	0	0	0	0	0	0	0	0	0	0	(1,660)	27
28	TOTAL General Administration	(34,605)	32,517	(10,326)	0	0	0	0	0	0	0	0	(12,414)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,201)	32,517	(10,311)	0	0	0	0	0	0	0	0	(22,995)	29

Summary B

12-31-2004

[illegible]

Facility Name & ID Number St. Ann's Healthcare Center# 0023390Report Period Beginning: 01-01-2004 Ending: 12-31-2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Blain Richard	50	St. Ann's Healthcare	Chester	RDR Mgmt	Hoyleton	MGMT
Blain Richard	25	Clinton Manor	New Baden			
Mike & Gail Greer	100	Ofallon Healthcare	Ofallon	Greer Mgmt	Trenton	MGMT
Mike & Gail Greer	50	St. Ann's Healthcare	Chester			
Mike & Gail Greer	25	Clinton Manor	New Baden			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	\$	RDR MGMT Lease		\$ 1,966	\$ 1,966	1
2	V	17	Management	36,000	RDR MGMT		31,581	(4,419)	2
3	V	21	Clerical/office				31,581	31,581	3
4	V	19	Legal/Accounting				359	359	4
5	V	22	Payroll Taxes				4,996	4,996	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 36,000			\$ 70,483	\$ * 34,483	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Ann's Healthcare Center# 0023390Report Period Beginning: 01-01-2004 Ending: 12-31-2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 MANAGEMENT	\$ 36,000	GREER MGMT		\$ 11,406	\$ (24,594)	15
16	V	21 CLERICAL		GREER MGMT		7,499	7,499	16
17	V	21 OFFICE SUPPLIES		GREER MGMT		1,731	1,731	17
18	V	22 PAYROLL TAXES		GREER MGMT		1,538	1,538	18
19	V	24 SEMINAR		GREER MGMT		478	478	19
20	V	21 TELEPHONE		GREER MGMT		1,138	1,138	20
21	V	6 REPAIRS & MAINT		GREER MGMT		15	15	21
22	V	20 DUES/SUBSCRIPT		GREER MGMT		956	956	22
23	V	19 PROFESSIONAL FEES		GREER MGMT		928	928	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 36,000			\$ 25,689	\$ * (10,311)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number St. Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2004 Ending: 12-31-2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Blain Richard	Pres	Officer	50.00	St. Anns	20	50.00		\$		1
2	Mike Greer	Sec	Officer	50.00	St. Anns	8	20.00				2
3	Mike Greer	Pres	Ofallon	100.00		8	20.00				3
4	Blain Richard	Pres	RDR MGMT	100.00	St. Anns	10	25.00	MGMT Fees	36,000	17-3	4
5	Mike Greer	Pres	Greer MGMT	100.00	St. Anns	10	25.00	MGMT Fees	36,000	17-3	5
6	Mike Greer	Greer MGMT	Ofallon	100.00	44,000	10	25.00				6
7	Mike Greer	Greer MGMT	Clinton	25.00	36,000	2	5.00				7
8	Blain Richard	RDR Mgmt	Clinton	25.00	36,000	5	13.00				8
9	Blain Richard	RDR Mgmt	So Ill Comm Sp	25.00	15,236	5	13.00				9
10	Mike Greer	Greer MGMT	So Ill Comm Sp	25.00	15,236	2	5.00				10
11											11
12											12
13								TOTAL	\$ 72,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Ann's Healthcare Center# 0023390

Report Period Beginning:

01-01-2004Ending: 2-31-2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization RDR ManagementStreet Address 19431 Sassafras RdCity / State / Zip Code Hoyleton, IL 62803Phone Number (618-478-5779Fax Number (618-478-2086

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Administrative	Management Fees	75,236	3	\$ 66,000	\$ 66,000	36,000	\$ 31,581	1
2	21 Clerical	Management Fees	75,236	3	66,000	66,000	36,000	31,581	2
3	19 Accounting	Management Fees	75,236	3	661		36,000	316	3
4	19 Legal	Management Fees	75,236	3	90		36,000	43	4
5	21 Office	Management Fees	75,236	3	1		36,000	0	5
6	22 Payroll Taxes	Management Fees	75,236	3	10,441		36,000	4,996	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 143,193	\$ 132,000		\$ 68,517	25

Facility Name & ID Number St. Ann's Healthcare Center# 0023390 Report Period Beginning: 01-01-2004Ending: 2-31-2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization GREER MGMTStreet Address 581 COUNTRYSIDE LANECity / State / Zip Code TRENTON,IL 62293Phone Number (618-224-7715Fax Number (618-224-7716

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMINISTRATIVE	MANAGEMENT FEES	119,246	4	\$ 37,780	\$ 37,780	36,000	\$ 11,406	1
2	21 CLERICAL	MANAGEMENT FEES	119,246	4	24,839	24,839	36,000	7,499	2
3	22 PAYROLL TAXES	MANAGEMENT FEES	119,246	4	5,734		36,000	1,731	3
4	21 OFFICE SUPPLIES	MANAGEMENT FEES	119,246	4	5,094		36,000	1,538	4
5	24 SEMINAR	MANAGEMENT FEES	119,246	4	1,584		36,000	478	5
6	21 TELEPHONE	MANAGEMENT FEES	119,246	4	3,771		36,000	1,138	6
7	6 REPAIRS & MAINT	MANAGEMENT FEES	119,246	4	50		36,000	15	7
8	20 DUES/SUBSCRIPT	MANAGEMENT FEES	119,246	4	3,166		36,000	956	8
9	19 PROFESSIONAL FEES	MANAGEMENT FEES	119,246	4	3,074		36,000	928	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 85,092	\$ 62,619		\$ 25,689	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First National Bank		X	Mortgage	\$9,436.74	10-03-01	\$ 850,000	\$ 602,758	10-15-06	4.7800	\$ 27,837	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Owners Loans	X		Cash Flow		04-01-04	729,000	729,000	03-31-05	4.5000	27,293	6	
7	Village Bank		X	Auto Loan	\$578.00	12-01-99	27,740		11-30-04	8.2500	142	7	
8	Buena Vista		X	Line of Credit		01-01-03	50,000	192,030			5,231	8	
9	TOTAL Facility Related				\$10,014.74		\$ 1,656,740	\$ 1,523,788			\$ 60,503	9	
	B. Non-Facility Related*												
10	Investment Interest		X								(3,970)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,970)	14	
15	TOTALS (line 9+line14)						\$ 1,656,740	\$ 1,523,788			\$ 56,533	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **St. Ann's Healthcare Center**# **0023390** Report Period Beginning: **01-01-2004** Ending: **12-31-2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	16,977	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	33,028	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	16,051	3	
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	16,977	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	33,028	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	27,526	8		
	2000	29,522	9		
	2001	30,471	10		
	2002	30,757	11		
	2003	33,028	12		
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Ann's Healthcare Center COUNTY Randolf

FACILITY IDPH LICENSE NUMBER 0023390

CONTACT PERSON REGARDING THIS REPORT Mike Greer

TELEPHONE 618-826-2314 FAX #: 618-826-5047

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-034-014-00</u>	<u>NURSING HOME</u>	\$ <u>2,261.96</u>	\$ <u>2,261.96</u>
2. <u>18-037-005-00</u>	<u>NURSING HOME</u>	\$ <u>91.16</u>	\$ <u>91.16</u>
3. <u>18-034-011-00</u>	<u>NURSING HOME</u>	\$ <u>30,243.34</u>	\$ <u>30,243.34</u>
4. <u>18-034-009-00</u>	<u>NURSING HOME</u>	\$ <u>78.04</u>	\$ <u>78.04</u>
5. <u>18-037-006-00</u>	<u>NURSING HOME</u>	\$ <u>139.64</u>	\$ <u>139.64</u>
6. <u>18-040-003-00</u>	<u>NURSING HOME</u>	\$ <u>214.10</u>	\$ <u>214.10</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>33,028.24</u></u>	\$ <u><u>33,028.24</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet: 50,246
 B. General Construction Type: Exterior Brick Frame Wood, Seel,Concrete Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	103,500	1977	\$ 20,000	1
2					2
3	TOTALS	103,500		\$ 20,000	3

Facility Name & ID Number St. Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2004 Ending: 12-31-2004

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1977	1937	\$ 404,102	\$	20	\$		\$ 404,102	4
5	46		1977	1976	250,000	7,327	33	7,327	7,327	212,142	5
6	10		1985	1985	104,150	3,171	33	3,171	3,171	62,660	6
7	15		1987	1987	344,144	10,417	33	10,417	10,417	180,943	7
8			1991	1991	357,704	11,964	30	11,964	11,964	155,317	8
	Improvement Type**										
9	BUILDING IMP			1978	500		8			500	9
10	NEW ROOF			1983	9,450		15			9,450	10
11	BUILDING IMP			1983	4,469		15			4,469	11
12	ELECTRICAL IMP			1985	3,130		15			3,130	12
13	ROOF REPAIRS			1987	1,830	92	20	92		1,569	13
14	FIRE ALARM			1987	3,900		8			3,900	14
15											15
16	NEW ROOF			1989	4,000	202	15	202		4,000	16
17	PARKING LOT			1991	7,708		10			7,708	17
18	BUILDING IMP			1992	12,806	502	20	502		9,249	18
19	TELEPHONE SYSTEM			1992	10,071		10			1,071	19
20	CUBICLE TRACK			1992	6,531		8			6,531	20
21	LAND IMP			1993	1,897	127	15	127		1,409	21
22	A/C UNIT			1984	5,625		8			5,625	22
23	BUILDING IMP			1994	45,734	1,819	20	1,819		28,608	23
24	BUILDING IMP			1993	10,012		10			10,012	24
25	PAINTING			1995	11,460	1,191	10	1,191		11,460	25
26	ROOF REPAIRS			1995	11,167	561	20	561		5,552	26
27	HANDRAILS			1995	20,700		8			20,700	27
28	BOILER			1995	21,690	1,455	15	1,455		13,234	28
29	ELECTRICAL, FIRE ALARM			1997	12,017	1,168	8	1,168		8,738	29
30	NEW ROOF			1999	30,546	1,535	20	1,535		8,673	30
31	NEW ROOF			2000	3,990	266	15	266		1,131	31
32	A/C UNIT			2000	7,265	907	8	907		4,392	32
33	FLOORING			2004	15,971	714	15	714		714	33
34	A/C UNIT			2004	6,378	269	8	269		269	34
35	SECURITY ALARM			2004	5,143	259	8	259		259	35
36	WASHER			2004	7,887	164	8	164		164	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,741,977	\$ 44,110		\$ 44,110	\$ 32,879	\$ 1,187,681	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 188,554	\$ 17,891	\$ 19,857	\$ 1,966	8	\$ 150,635	71
72	Current Year Purchases	28,074	1,921	1,921		8	1,921	72
73	Fully Depreciated Assets	30,322				8	30,322	73
74								74
75	TOTALS	\$ 246,950	\$ 19,812	\$ 21,778	\$ 1,966		\$ 182,878	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	85 Chev Bus	1996	\$ 6,000	\$	\$		3	\$	76
77	Facility	96 Dodge Van	2001	4,463	1,487	1,487		3	1,858	77
78	Facility	Van	2001	17,811	3,622	3,622		3	10,867	78
79										79
80	TOTALS			\$ 28,274	\$ 5,109	\$ 5,109	\$		\$ 12,725	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,037,201	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,031	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,997	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,966	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,383,284	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ADM Auto	\$ 27,739	\$	\$ 27,739	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 27,739	\$	\$ 27,739	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				33,344		33,344	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Pharmacy Billing						(2,034)		(2,034)	13
14	TOTAL			\$		\$	\$ 31,310		\$ 31,310	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (62,420)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (7,343))	950,307		3
4	Supply Inventory (priced at FIFO)	33,177		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,680		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 936,744	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,781,897		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	319,016		16
17	Accumulated Depreciation (book methods)	(1,460,522)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 665,391	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,602,135	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,378	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,023		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,925		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,404		32
33	Accrued Interest Payable	20,404		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 206,134	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	729,000		39
40	Mortgage Payable	602,758		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Line of Credit</u>	192,030		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,523,788	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,729,922	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (127,787)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,602,135	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (65,939)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (65,939)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(65,074)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Residential Div	3,226	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (61,848)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (127,787)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,708,573	1
2	Discounts and Allowances for all Levels	184,648	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,893,221	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	241,831	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 241,831	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	8,550	12
13	Barber and Beauty Care	8,678	13
14	Non-Patient Meals	5,324	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,355	17
18	Sale of Supplies to Non-Patients	1,249	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 71,156	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,970	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain On sale of Property	49,572	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 49,572	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,259,750	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	732,286	31
32	Health Care	1,679,373	32
33	General Administration	629,422	33
	B. Capital Expense		
34	Ownership	162,562	34
	C. Ancillary Expense		
35	Special Cost Centers	55,849	35
36	Provider Participation Fee	65,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,324,824	40
41	Income before Income Taxes (line 30 minus line 40)**	(65,074)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (65,074)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number St. Ann's Healthcare Center# 0023390Report Period Beginning: 01-01-2004Ending: 12-31-2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,095	2,119	\$ 55,554	\$ 26.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,972	7,436	128,452	17.27	3
4	Licensed Practical Nurses	22,131	23,915	327,809	13.71	4
5	Nurse Aides & Orderlies	52,701	55,622	495,268	8.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,855	4,239	49,901	11.77	8
9	Activity Director	1,926	2,046	22,035	10.77	9
10	Activity Assistants	1,512	1,760	14,294	8.12	10
11	Social Service Workers	3,450	3,578	35,467	9.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,754	5,208	62,773	12.05	15
16	Dishwashers	17,966	18,990	133,893	7.05	16
17	Maintenance Workers	4,878	5,071	48,505	9.57	17
18	Housekeepers	8,406	8,982	75,111	8.36	18
19	Laundry	6,943	7,467	56,157	7.52	19
20	Administrator	1,795	1,843	54,569	29.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,935	8,559	97,981	11.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,319	156,835	\$ 1,657,769 *	\$ 10.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	100	\$ 4,883	1-3	35
36	Medical Director				36
37	Medical Records Consultant	72	3,796	10-3	37
38	Nurse Consultant		2,614	10-3	38
39	Pharmacist Consultant	108	1,540	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	2,553	11-3	44
45	Social Service Consultant	120	3,560	12-3	45
46	Other(specify) <u>Religious</u>		1,050	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	496	\$ 19,996		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
Tom Selders	ADM		\$ 54,569	Workers' Compensation Insurance		\$ 53,408	IDPH License Fee	\$
				Unemployment Compensation Insurance		20,773	Advertising: Employee Recruitment	942
				FICA Taxes		122,966	Health Care Worker Background Check	
				Employee Health Insurance		17,660	(Indicate # of checks performed 41)	453
				Employee Meals		3,896	Ill Healthcare Assoc	6,993
				Illinois Municipal Retirement Fund (IMRF)*			Sec of State	482
				401k Plan		585	Advertising	32,029
							Notary	113
TOTAL (agree to Schedule V, line 17, col. 1)							Subscriptions	1,449
(List each licensed administrator separately.)			\$ 54,569				Chamber of Com	345
B. Administrative - Other							Less: Public Relations Expense	(571)
							Non-allowable advertising	(32,029)
Description			Amount				Yellow page advertising	(345)
RDR MGMT			\$ 36,000					
Greer MGMt			36,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 72,000	TOTAL (agree to Schedule V,		\$ 219,288	TOTAL (agree to Sch. V,	\$ 9,861
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Herman Bodewes	Legal		\$ 851				Out-of-State Travel	\$
WDM Computer Serv Inc.	Accounting/Data Proc		19,925					
							In-State Travel	
							Seminar	9,660
							Seminar Expense	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 20,776				line 24, col. 8)	\$ 9,660

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. III Healthcare Assoc 6993
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? 571
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,524 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,332
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,896 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,324
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 50
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? N
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.